Payment Reform and PCMH

Montana PCMH Stakeholder Council
February 19, 2014

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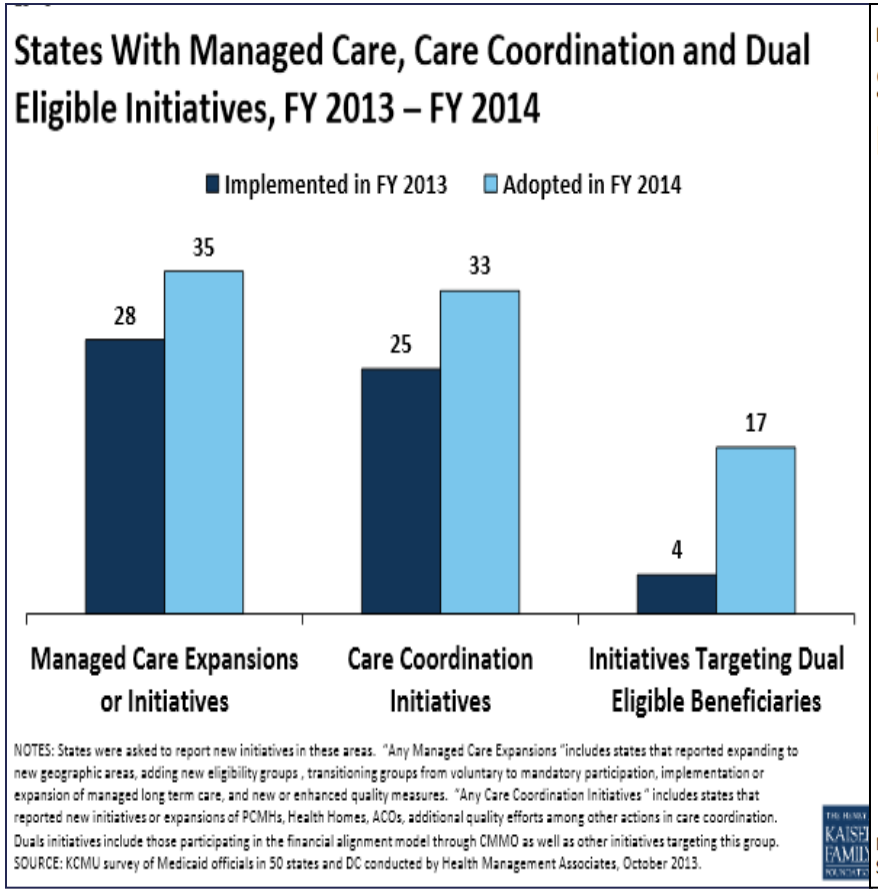
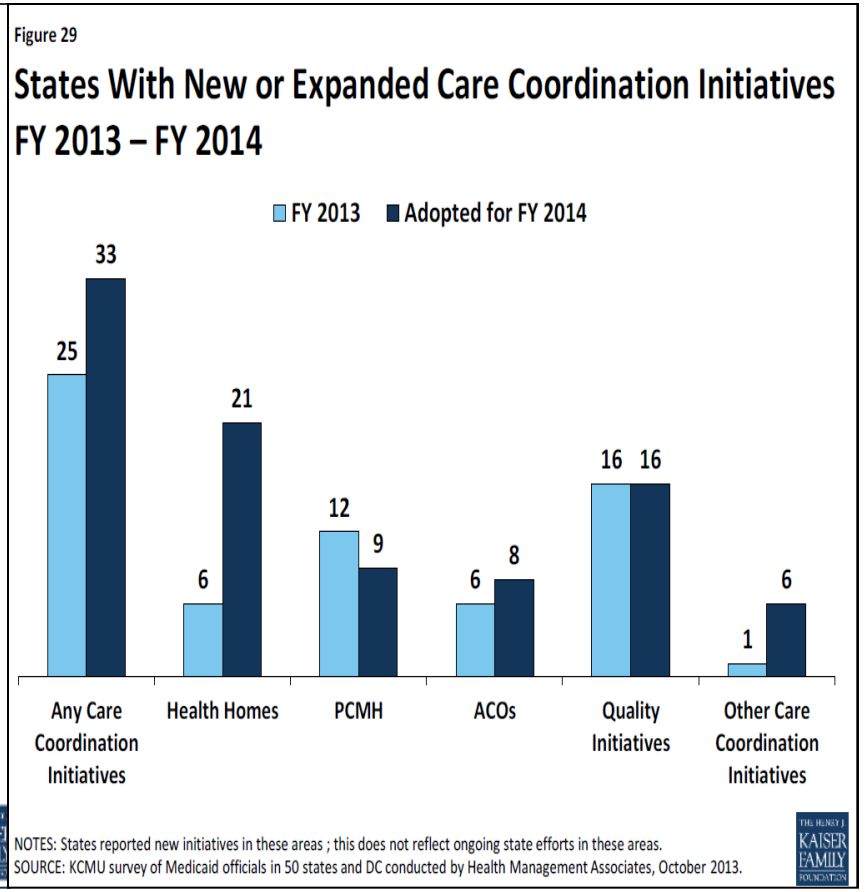
State Payment and Delivery System Reform

- At the top of many State agendas
- Driven by a number of factors:
  - Continual pressure on states' Medicaid budgets
  - Triple Aim – better care, better outcomes, lower cost
  - Health reform role in accelerating the speed
- Results from most recent KFF Survey document the level of state activity on this front
- Much to be learned from experiences in other states

Background: State Activity



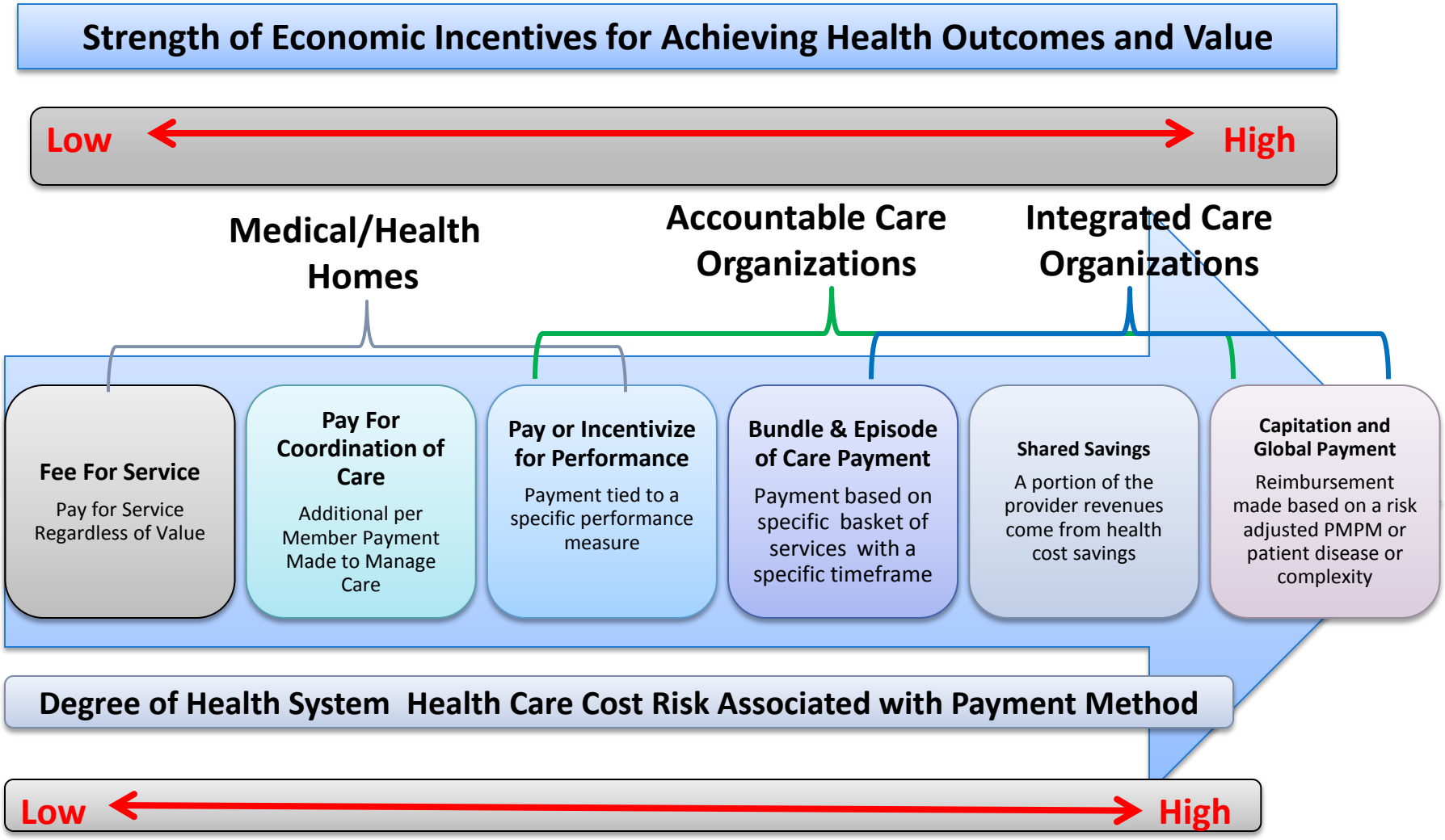


Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014, October 2013, available at http://kff.org/medicaid/

Payment Reform Models

- Important to Remember: payment reform ≠ delivery system reform
- Goal: Use a payment mechanism that adequately pays for and appropriately incentivizes providers to coordinate and manage care; should go hand in glove with system delivery reform
- Spectrum of payment models that requires providers to take on greater financial responsibility ("risk")
- Incorporating quality and outcomes into payment reform equation

Health System Models and Aligned Payment Methods



Key Considerations

- Overall vision for reform of the health care delivery system
- Assessment of where state currently sits on the payment/delivery reform continuum
- Federal authorities or pathways available to a particular state to implement reform
  - (e.g., whether state currently uses 1915(b) or 1115 waiver authority, or is a fee for service state)
- Identifying the resources to transition to new payment/delivery system models

Key Considerations

- Capacity of providers to assume risk
- Local market factors
  - Rural vs. urban areas or prevalence of large integrated hospital systems in a particular market place
- Capacity of state staff
- Stakeholder engagement and input
- Political considerations
- Population and geographic differentiation

Patient Centered Medical Home Payment Models

States building off Medicaid Primary Care Case Management (PCCM) infrastructure to move to PCMH

Mary Takach *Health Affairs* study reported that 25 States using Medicaid/CHIP to support PCMH in 2012

- Large majority pay providers a PMPM care management fee
- Fees vary considerably from state to state and often adjusted for patient age, acuity and PCMH level
- Fourteen of the states provide performance-based payments but only a handful provide upfront payments

Adoption of PCMH model in Medicaid continuing to grow

PCMH Payment Models

Ten Payment Models Identified by Safety Net Medical Home Initiative:

- FFS with new codes for PCMH
- FFS with higher payment levels
- FFS with lump sum payments
- FFS with PMPM payments
- FFS with PMPM payment and P4P
- FFS with PMPY Shared Savings Payment
- FFS with lump sum payments, P4P and Shared Savings
- FFS with PMPY payment and shared savings
- Comprehensive payment with P4P
- Grants

State Examples

- Rhode Island Chronic Care Sustainability Initiative
  - Tiered Per Member per month care management fee based on number of performance target a practice achieves
  - Hospital utilization, clinical quality, and patient experience are three target areas
- Connecticut
  - Level 2 and 3 PCMHs receive enhanced FFS and participate in P4P
  - “Glide Path” Option for Practices below Level 2
- Pennsylvania
  - Fixed medical home payment plus a second payment adjusted for age
  - Shared savings approach

Approved State Health Homes SPAs Under the ACA

- Mechanism to provide care for individuals with multiple chronic conditions, particularly behavioral health. States receive enhanced match for 2 years.
- SPA approval:
  - 14 states approved to date
  - 3 of those states have two approved SPAs for particular populations
  - Recent KFF/HMA survey reports that 21 states plan to adopt or expand use of health homes in 2014
- Payment methodology:
  - Generally, states have used a PMPM approach
  - Some use of P4P
  - At least one state exploring shared savings approach

State Examples

- Missouri (MO) first state to receive approval for health home SPA. In establishing PMPM, MO estimated the costs required for health home provider to develop necessary clinical and administrative capability
- Iowa has built risk adjustment and P4P into health home model
- Maine building on existing multi-payer initiative that includes both a PCMH primary care practice and a partnering CCT to provide services to highest need members
- NY exploring a shared savings approach

Other Payment and Delivery Reform Models

- ACOs -- Though initially viewed primarily as a Medicare model, gaining traction in Medicaid space (CO,MN, NJ)
  - Variety of payment mechanisms used, but commonly shared savings or shared savings/losses
- Bundled Payments – Arkansas Payment Improvement Initiative
- Risk-Based Managed Care
- Global Payments -- Oregon

One State's Path: *PA Access Plus Program*

- Born from a PMPM provided to PCPs for care management and access
- Vendor Contract for EPCCM Services in 42 Rural FFS Counties
- P4P to Providers that evolved from Pay for Participation to Pay for Performance
- Shared Savings with Upside and Downside Risk for Vendor and P4P on Quality Indicators
- Access Plus integrated into Medicare Multi-Payer Advanced Primary Care Practice Demonstration
- Shared Savings incorporated into Multi-Payer Demonstration

Latest Twist: State Eliminated ACCESS Plus and Implemented Full Risk Capitated Managed Care

PA Medicaid P4P Metrics

- Adolescent Well-Care Visits
- Annual Dental Visits
- Breast Cancer Screening
- Cervical Cancer Screening
- Cholesterol Management: LDL Control < 100
- Comp. Diabetes Monitoring: HbA1c Poor Control
- Comp. Diabetes Monitoring: LDL Control < 100
- Controlling High Blood Pressure
- Emergency Room Utilization
- Frequency of Prenatal Care
- Lead Screening in Children
- Prenatal Care in 1st Trimester

P4P Lessons Learned

- Utilize a limited set of metrics of importance to health care in Montana
- Align with other quality measurement efforts – at Federal level (EHR Meaningful use), state (Medicaid adult and adult child core measures), and private payer level (HEDIS)
- Include metrics across the domains of access; prevention; clinical effectiveness; experience of care; utilization and resource use
- Use consistent metrics year to year – quality improvement takes time
- Pay attention to ROI; important for sustainability of effort
- Multi-Payer can bring most power to transformation effort; but all payers, including Medicaid, will need to see the value
- Finding right balance no easy trick

Key Take-Aways

- Much activity on payment/system delivery reform and states are at varying points along the continuum
- Important to remember that payment reform does not necessarily equal delivery system reform
- States are experimenting with a number of ways to accomplish this
- There are multiple paths to achieve the same goal – One size does not fit all
- States are still all in pursuit of the Holy Grail -- the right combination that will achieve better care for consumers and improved health outcomes, while containing health costs.